



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FUNCTIONAL PERFORMANCE REHABILITATION
CONSULTANTS

Respondent Name

INDEMNITY INSURANCE CO OF NORTH
AMERICA

MFDR Tracking Number

M4-13-1713-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

MARCH 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "My office is requesting your assistance in getting the services paid for date of service April 10, 2012. [Claimant] was evaluated by Dr. Charles W. Kennedy Jr. on April 10, 2012 for a Designated Doctor Exam to address Extent of Injury, Disability and Return to Work. For Dr. Kennedy to address the return to work he referred [Claimant] for functional testing that took place that same day, April 10, 2012. Unfortunately my billing department on the first HCFA 1500 put the wrong date of April 11, 2012 and this bill was denied as it should have been. However since then my office made the necessary corrections and to this date this bill continued to be denied. I am requesting your assistance in getting this date of services for the FCE that the DDE requested paid in full."

Amount in Dispute: \$720.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2012	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$720.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.

4. The services in dispute were reduced / denied by the respondent with the following reason codes:
- 663-022-Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed.
5. Is The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 14, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for code 97750-FC based upon reason code "663-022."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

The requestor originally billed the requestor with the incorrect date, April 11, 2012, within 95 days. The respondent denied reimbursement stating, "57-Report date and service date do not coincide."

28 Texas Administrative Code §133.20(g) states "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." The requestor corrected the bill and submitted the new bill to the respondent for payment. The respondent issued an EOB dated August 1, 2012 denying payment for the disputed service based upon reason code "663-022".

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The requestor did not submit any documentation to support that the bill dated April 10, 2012 was submitted timely within 95 days to the respondent. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

04/24/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.